MEDICAID BASICS:

Answering your questions about Adult Medicaid and the Spend Down Provision

Adult Medicaid

- Medicaid is a federal and state funded program which pays for the medical care of persons who meet specific categorical non-financial, income and resource requirements.
- Individuals can be eligible for either full, limited or emergency Medicaid depending on the category under which they qualify.
- There are also programs called Medicare Savings Plans that assist with the payment of the Medicare Part B premium, Medicare co-Pays and deductibles.

Legal Basis

- The Medicaid program was established under Title XIX of the Social Security Act.
- The Health Care Financing Administration of the Department of Health and Human Services is the federal agency which has administrative responsibility for the Medicaid Program.
- Medicaid became effective in Indiana on January 1, 1970.

How To Apply

- An applicant may apply online at www.ifcem.com
- An applicant may call 1-800-403-0864 and request a paper application be mailed to them
- An applicant may visit the local office where they can utilize computers in the lobby and receive assistance if needed

2013 Resource Standards

- For Medicaid A, Medicaid B and Medicaid D: the single person limit is $1500 and for a married couple the limit is $2250
- For Medicare Savings programs: QMB (Medicaid L), SLMB (Medicaid J) or QI (Medicaid I): the single person limit is $7080 and for a married couple the limit is $10,620
- There is a different set of standards for an applicant who is in a long term care facility and has a spouse living in the community.

2013 Income Standards for the Disabled, Blind or Aged

- $710 – an unmarried applicant/recipient of any age, or married applicant/recipient not living with a spouse
- $1066 – a married couple, either or both of whom are applicants/recipients

How Income effects Eligibility

- Medicaid policy factors in a series of deductions according to the composition of the assistance group (the applicant/recipient and specific members of their family such as a spouse or dependent children) and the type of income received.
- After all deductions are applied the outcome is compared to the appropriate Federal standard.
- If a person has income in excess of the standard it does not mean they cannot qualify. It may mean they fall under the Spend Down provision.
- The Spend Down is like an insurance deductible.

SPEND DOWN OR NO SPEND DOWN?

- If the result is less than the Federal standard there will be no spend down for the applicant/ recipient. (Individuals with only SSI income will not have a spend down.)

- If the result is more than the Federal standard this amount (rounded down to the next whole dollar amount) will be the Gross Spend down. The next step is to subtract any allowable health insurance premiums.

Health Insurance Premiums

- Premiums for medical and/or hospitalization coverage are allowed as a deduction including the amount of the Medicare Part D premium that exceeds the current Benchmark.

  (2013= $37.22)

- The applicant and any financially responsible relatives whose income is included are allowed this deduction.

- The result after allowable deductions are applied is the Net Spend down.

Premium payments not allowed

- Health and accident policies that pay lump sum settlements for death or dismemberment
- Income maintenance policies that will pay mortgage or loan payments while the insured is disabled
- Indemnity policies that do not limit benefits to the reimbursement of medical expenses

CATEGORIES SUBJECT TO THE SPEND DOWN PROVISION

- Medicaid for the Aged
- Medicaid for the Disabled
- Medicaid for the Blind

Shared (Couple) Spend down

- When both members of a married couple qualify for Medicaid and there is income in excess of the Federal standard there will be a shared spend down.
- He can meet it all, she can meet it all or it can be a combination of expenses for each of them.

Immediate Access to Services

- Recipients approved for Medicaid with a spend down have access to Medicaid covered services on the first day of every month in which they are enrolled.
- Recipients must incur an expense to meet spend down and provide proof of the expense, not proof they have already paid for the services received.
- If the recipient has no need for medical services in a specific month they do not pay anything. It is a common misconception that spend down recipients must pay their spend down amount every month.

Coverage of Last Resort

- When a Medicaid recipient has other health insurance medical providers must submit charges to the other insurance companies first.
- Medical expenses that are subject to payment by a third party will not be considered for meeting the spend down until the third party adjudicates the claim. When they have paid for services that are covered by that policy any remaining balance can be submitted to Medicaid.

Medical billing procedures

- Recipients with a spend down must incur expenses equal to or in excess of the spend down amount before Medicaid will pay for any of their services.
- Recipients make payments to meet their spend down to the provider of the services received- not to the Medicaid program.
- Medical providers such as doctors, hospitals, pharmacies, etc. file claims electronically to Indiana AIM for services to spend down recipients and the spend down amount is deducted from what is claimed.

EXAMPLE:

- John Jones has a spend down of $50. He does not qualify for Medicare.
- The first medical expense for the month is a prescription he refills at his pharmacy that costs $75.
- He is responsible for his pharmacy co-pay of $3 and the next $47 to meet his spend down. John pays $50 to the pharmacy. Medicaid pays the balance.
- Any other prescriptions he has filled that month will only cost $3. Other allowed medical services that month will be paid by Medicaid.
- Any additional pharmacy co-pays that month are automatically applied to his spend down the following month.

Allowable Medical expenses to credit Spend Down

1. Medical care from physicians, psychiatrists and other licensed medical practitioners.
2. Laboratory testing, x-rays and other diagnostic procedures.
3. Dental services including dentures provided by a licensed dentist.

4. Hospitalization and outpatient treatment.
5. Nursing facility services and rehabilitative services.
6. Respiratory, occupational, speech, physical, and audiology therapy services.
7. Prescription drugs and OTC medications (including insulin) when prescribed by a licensed medical practitioner.

Please note:

- For Medicare beneficiaries this would be for drugs excluded from coverage under Medicare D.
- Excluded drugs include barbiturates, benzodiazepines and OTC drugs covered by Medicaid.**

**Addendum: as of 2013, these drugs ARE now covered

8. The cost of postage for the purchase of mail order prescriptions*.
9. Medical supplies if ordered in writing by a licensed physician or dentist for treatment of a medical condition.*
10. Durable medical equipment if ordered in writing by a physician.
11. Home health care by a licensed agency.
12. Nursing services by an RN or LPN.

13. Audiology services and hearing aids if ordered in writing by a physician.
14. Prosthetic devices other than those dispensed for purely cosmetic purposes when ordered in writing by a physician.
15. Vision care services, including exams, eyeglasses and diagnostic procedures.
16. The cost of transportation to obtain medical services that qualify as allowable expenses*.

17. The premium of a recipient's spouse who is on the Med Works program*.
18. Co-payments required by other health insurance that covers the recipient, including Medicare Part D co-pays*.
19. Any waiver service approved for the individual who is approved under one of the Medicaid Home and Community Services*.
20. Targeted case management services to pregnant women, individuals with HIV and individuals receiving services from a community mental health center under the Medicaid rehabilitation option*.

Transportation*

- If transportation is provided by a business transportation carrier, the verified carrier's charge will be allowed. These providers will likely have the means to submit the expense electronically. If it is provided by a non-business carrier a record of the provider's name, address and date of service must be provided. These providers may or may not be able to file electronically. If submitted as a Non-Claim DFR staff can use Map Quest or a similar website to determine the distance traveled.

- If the recipient, his friend or his family member drives the recipient to medical services mileage costs is allowed. The current rate is $ .44 per mile, round trip. DFR staff can use Map Quest or a similar website to determine the distance traveled. This type will always be a Non-Claim.

QMB Recipients

- For Medicaid D, Medicaid A and Medicaid B recipients who also have QMB coverage, their Medicare co-insurance and deductibles will not credit spend down since QMB is paying those costs.

Other Expenses Allowed for meeting Spend Down

- Certain allowable medical expenses cannot be filed as claims directly to AIM.
- These are referred to as Non-Claims.
- These must be submitted to the Division of Family Resources where they are posted and electronically submitted to AIM.
- The items on the previous list with an asterisk usually always need to be submitted as a Non-Claim.

How Non-Claims are applied

- If no other instructions are given when Non-Claim expenses are submitted they will be applied to spend down in the month following the month the DFR receives the documentation.

- If the recipient wants the Non-Claim expense applied to the month when services were received or to the current month the recipient must specify how they want those expenses applied.

Non-Claim Expense Types

1. Allowable expenses that are paid by the CHOICE program or the Township Trustee. This would require very specific documentation that lists the specific service provided and the procedure code.

2. Services from medical providers who do not participate in the Medicaid program.

3. Medical expenses received by non-recipient spouses or parents whose income was used to determine the spend down.

4. Co-payments required by other insurance coverage and Medicare.

5. Bills for medical services received before the recipient became eligible for Medicaid.

Verification of Non-Claim Medical Expenses

- Adequate documentation will include the type and amount of the expense, the date the expense was incurred, if the expense is subject to reimbursement by a third party, and the reimbursed amount.

Acceptable Documentation

- A bill from a provider
- A receipt from a provider
- A written statement from a provider
- A telephone contact by the DFR to the provider, as a last resort.
- Medicare Summary Notices

Spend Down Summary Notices

- On the second business day of every month AIM generates notices to spend down recipients for whom claims or Non-Claims were applied.
- More than one month's claim activity may be listed and the summary reports all claims processed in the previous month regardless of the date of service.

Retention of Summary Notices

- Every recipient and authorized representative should keep the notices as a record of how and to what services their spend down was applied.
- The notice informs them of the amount of the spend down that they owe to each medical provider.

Questions

- If the recipient should have specific questions about amount shown as due to a provider they should contact the provider first.
- Providers receive a weekly Remittance Advice of how claims were applied.
- What is on the Summary Notice and what is reported on the RA should match.

Problem Resolution

- Most discrepancies can be resolved with a call to the medical provider.
- The Local Office does not receive copies of the Summary and do not have access to information to answer questions of this nature.
- If a problem of this kind cannot be resolved with the providers office recipients or their authorized representatives can call Member Services at (317) 713-9627 or (800) 457-4584.
- Recipients have the right to appeal any information on the Summary Notice with which they do not agree.

Other Miscellaneous Concerns

- What SHIP can do to help
- Questions about the Affordable Care Act
- LIS or the Extra Help program

How SHIP Counselors can help

- SHIP counselors can become authorized representatives for Medicaid recipients they are working with.
- They can call 1-800-403-0864 if they are not an authorized representative but have the recipient in their office at the time.
- They can contact DFR.region4 to obtain details for accessing the Provider Portal.

The Affordable Care Act

- FSSA cannot yet answer questions about how the ACA will effect the Medicaid program and specifically Spend Down. Details are set to be released in the Fall of 2013.

Home and Community Based Medicaid Waivers

- The Aged and Disabled Waiver (A & D) provides an alternative to nursing facility admission for adults and persons of all ages with a disability.
- Individuals in need of services begin the application process by contacting their Area Agency on Aging, also referred to as Triple A.

Screening

- An initial screening can be completed by phone and if it is determined that the individual meets the required Level of Care for services an in-home assessment will be scheduled.
- If the in-home assessment confirms the need the individual is placed on the waiting list.

Top of the List

- When an individual reaches the top of the waiting list another assessment is done to determine if anything has changed.
- If the individual is on Medicaid, Waiver services can begin.
- If the individual is not on Medicaid their application can be placed “on hold” for a brief period of time while a Medicaid application is filed.
- If the Medicaid application process is not completed within approximately 2-3 months their name is removed from the list. A new application would be required and the process begins again.

Reduction or cancellation of the Spend down

- Many Medicaid recipients with a Spend down who become eligible for Waiver services experience a change in their Spend down status.
- DFR becomes aware of Waiver eligibility through a data exchange process and takes appropriate action to update the case.
- Each individual is unique and is handled on a case by case basis.

Low Income Subsidy (LIS)

- The Low Income Subsidy, also referred to as Part D Extra Help is administered through CMS. Medicaid is involved to the extent that recipients of LIS must meet their Medicaid spend down a minimum of one time in the prior year to remain eligible.

Deemed Eligible

- According to SSA Medicare beneficiaries are automatically deemed eligible and should not apply for Extra Help:

1. If they have Medicaid
2. If they participate in a QMB, SLMB or QI program, or
3. Receive SSI